(d) of this section, the plan or issuer must provide the individual a written notice of the length of preexisting condition exclusion that remains after offsetting for prior creditable coverage. This individual notice is not required to identify any medical conditions specific to the individual that could be subject to the exclusion. A plan or issuer is not required to provide this notice if the plan or issuer does not impose any preexisting condition exclusion on the individual or if the plan's preexisting condition exclusion is completely offset by the individual's prior creditable coverage.

(1) *Manner and timing.* The individual notice must be provided by the earliest date following a determination that the plan or issuer, acting in a reasonable and prompt fashion, can provide the notice.

(2) *Content.* A plan or issuer must disclose—

(i) Its determination of any preexisting condition exclusion period that applies to the individual (including the last day on which the preexisting condition exclusion applies);

(ii) The basis for such determination, including the source and substance of any information on which the plan or issuer relied;

(iii) An explanation of the individual's right to submit additional evidence of creditable coverage; and

(iv) A description of any applicable appeal procedures established by the plan or issuer.

(3) *Duplicate notices not required.* If a notice satisfying the requirements of this paragraph (e) is provided to an individual, the obligation to provide this individual notice of preexisting condition exclusion with respect to that individual is satisfied for both the plan and the issuer.

(4) *Examples.* The rules of this paragraph (e) are illustrated by the following examples:

Example 1. (i) *Facts.* A group health plan imposes a preexisting condition exclusion period of 12 months. After receiving the general notice of preexisting condition exclusion, Individual *G* presents a certificate of creditable coverage indicating 240 days of creditable coverage. Within seven days of receipt of the certificate, the plan determines that *G* is subject to a preexisting condition exclusion of 125 days, the last day of which is March 5. Five days later, the plan notifies *G* that, based on the certificate *G* submitted, *G* is subject to a preexisting condition exclusion period of 125 days, ending on March 5. The notice also explains the opportunity to submit additional evidence of creditable coverage and the plan's appeal procedures. The notice does not identify any of *G*'s medical conditions that could be subject to the exclusion.

(ii) *Conclusion.* In this *Example 1*, the plan satisfies the requirements of this paragraph (e).

Example 2. (i) *Facts.* Same facts as in *Example 1*, except that the plan determines that *G* has 430 days of creditable coverage based on *G*'s certificate indicating 430 days of creditable coverage under *G*'s prior plan.

(ii) *Conclusion.* In this *Example 2*, the plan is not required to notify *G* that *G* will not be subject to a preexisting condition exclusion.

(f) *Reconsideration.* Nothing in this section prevents a plan or issuer from modifying an initial determination of creditable coverage if it determines that the individual did not have the claimed creditable coverage, provided that —

(1) A notice of the new determination (consistent with the requirements of paragraph (e) of this section) is provided to the individual; and

(2) Until the notice of the new determination is provided, the plan or issuer, for purposes of approving access to medical services (such as a pre-surgery authorization), acts in a manner consistent with the initial determination.

[69 FR 78783, Dec. 30, 2004, as amended at 75 FR 37235, June 28, 2010]

§ 146.113 Rules relating to creditable coverage.

(a) *General rules*—(1) *Creditable coverage.* For purposes of this section, except as provided in paragraph (a)(2) of this section, the term *creditable coverage* means coverage of an individual under any of the following:

(i) A group health plan as defined in § 146.145(a).

(ii) Health insurance coverage as defined in § 144.103 of this chapter (whether or not the entity offering the coverage is subject to the requirements of this part and 45 CFR part 148 and without regard to whether the coverage is offered in the group market, the individual market, or otherwise).

(iii) Part A or B of Title XVIII of the Social Security Act (Medicare).

(iv) Title XIX of the Social Security Act (Medicaid), other than coverage consisting solely of benefits under section 1928 of the Social Security Act (the program for distribution of pediatric vaccines).

(v) Title 10 U.S.C. Chapter 55 (medical and dental care for members and certain former members of the uniformed services, and for their dependents; for purposes of Title 10 U.S.C. Chapter 55, *uniformed services* means the armed forces and the Commissioned Corps of the National Oceanic and Atmospheric Administration and of the Public Health Service).

(vi) A medical care program of the Indian Health Service or of a tribal organization.

(vii) A State health benefits risk pool. For purposes of this section, a *State health benefits risk pool* means—

(A) An organization qualifying under section 501(c)(26) of the Internal Revenue Code;

(B) A qualified high risk pool described in section 2744(c)(2) of the PHS Act; or

(C) Any other arrangement sponsored by a State, the membership composition of which is specified by the State and which is established and maintained primarily to provide health coverage for individuals who are residents of such State and who, by reason of the existence or history of a medical condition—

(*1*) Are unable to acquire medical care coverage for such condition through insurance or from an HMO, or

(*2*) Are able to acquire such coverage only at a rate which is substantially in excess of the rate for such coverage through the membership organization.

(viii) A health plan offered under Title 5 U.S.C. Chapter 89 (the Federal Employees Health Benefits Program).

(ix) A public health plan. For purposes of this section, a *public health plan* means any plan established or maintained by a State, the U.S. government, a foreign country, or any political subdivision of a State, the U.S. government, or a foreign country that provides health coverage to individuals who are enrolled in the plan.

(x) A health benefit plan under section 5(e) of the Peace Corps Act (22 U.S.C. 2504(e)).

(xi) Title XXI of the Social Security Act (State Children's Health Insurance Program).

(2) *Excluded coverage.* Creditable coverage does not include coverage of solely excepted benefits (described in §146.145).

(3) *Methods of counting creditable coverage.* For purposes of reducing any preexisting condition exclusion period, as provided under §146.111(a)(2)(iii), the amount of an individual's creditable coverage generally is determined by using the standard method described in paragraph (b) of this section. A plan or issuer may use the alternative method under paragraph (c) of this section with respect to any or all of the categories of benefits described under paragraph (c)(3) of this section.

(b) *Standard method*—(1) *Specific benefits not considered.* Under the standard method, the amount of creditable coverage is determined without regard to the specific benefits included in the coverage.

(2) *Counting creditable coverage*—(i) *Based on days.* For purposes of reducing the preexisting condition exclusion period that applies to an individual, the amount of creditable coverage is determined by counting all the days on which the individual has one or more types of creditable coverage. Accordingly, if on a particular day an individual has creditable coverage from more than one source, all the creditable coverage on that day is counted as one day. Any days in a waiting period for coverage are not creditable coverage.

(ii) *Days not counted before significant break in coverage.* Days of creditable coverage that occur before a significant break in coverage are not required to be counted.

(iii) *Significant break in coverage defined*—A significant break in coverage means a period of 63 consecutive days during each of which an individual does not have any creditable coverage. (See also §146.143(c)(2)(iii) regarding the applicability to issuers of State insurance laws that require a break of more than

63 days before an individual has a significant break in coverage for purposes of State insurance law.)

(iv) *Periods that toll a significant break.* Days in a waiting period and days in an affiliation period are not taken into account in determining whether a significant break in coverage has occurred. In addition, for an individual who elects COBRA continuation coverage during the second election period provided under the Trade Act of 2002, the days between the date the individual lost group health plan coverage and the first day of the second COBRA election period are not taken into account in determining whether a significant break in coverage has occurred.

(v) *Examples.* The rules of this paragraph (b)(2) are illustrated by the following examples:

Example 1. (i) *Facts.* Individual *A* has creditable coverage under Employer *P*'s plan for 18 months before coverage ceases. *A* is provided a certificate of creditable coverage on *A*'s last day of coverage. Sixty-four days after the last date of coverage under *P*'s plan, *A* is hired by Employer *Q* and enrolls in *Q*'s group health plan. *Q*'s plan has a 12-month preexisting condition exclusion.

(ii) *Conclusion.* In this *Example 1*, *A* has a break in coverage of 63 days. Because *A*'s break in coverage is a significant break in coverage, *Q*'s plan may disregard *A*'s prior coverage and *A* may be subject to a 12-month preexisting condition exclusion.

Example 2. (i) *Facts.* Same facts as *Example 1*, except that *A* is hired by *Q* and enrolls in *Q*'s plan on the 63rd day after the last date of coverage under *P*'s plan.

(ii) *Conclusion.* In this *Example 2*, *A* has a break in coverage of 62 days. Because *A*'s break in coverage is not a significant break in coverage, *Q*'s plan must count *A*'s prior creditable coverage for purposes of reducing the plan's preexisting condition exclusion period that applies to *A*.

Example 3. (i) *Facts.* Same facts as *Example 1*, except that *Q*'s plan provides benefits through an insurance policy that, as required by applicable State insurance laws, defines a significant break in coverage as 90 days.

(ii) *Conclusion.* In this *Example 3*, under State law, the issuer that provides group health insurance coverage to *Q*'s plan must count *A*'s period of creditable coverage prior to the 63-day break. (However, if *Q*'s plan was a self-insured plan, the coverage would not be subject to State law. Therefore, the health coverage would not be governed by the longer break rules and *A*'s previous health coverage could be disregarded.)

Example 4. [Reserved]

Example 5. (i) *Facts.* Individual *C* has creditable coverage under Employer *S*'s plan for 200 days before coverage ceases. *C* is provided a certificate of creditable coverage on *C*'s last day of coverage. *C* then does not have any creditable coverage for 51 days before being hired by Employer *T*. *T*'s plan has a 3-month waiting period. *C* works for *T* for 2 months and then terminates employment. Eleven days after terminating employment with *T*, *C* begins working for Employer *U*. *U*'s plan has no waiting period, but has a 6-month preexisting condition exclusion.

(ii) *Conclusion.* In this *Example 5*, *C* does not have a significant break in coverage because, after disregarding the waiting period under *T*'s plan, *C* had only a 62-day break in coverage (51 days plus 11 days). Accordingly, *C* has 200 days of creditable coverage, and *U*'s plan may not apply its 6-month preexisting condition exclusion with respect to *C*.

Example 6. [Reserved]

Example 7. (i) *Facts.* Individual *E* has creditable coverage under Employer *X*'s plan. *E* is provided a certificate of creditable coverage on *E*'s last day of coverage. On the 63rd day without coverage, *E* submits a substantially complete application for a health insurance policy in the individual market. *E*'s application is accepted and coverage is made effective 10 days later.

(ii) *Conclusion.* In this *Example 7*, because *E* applied for the policy before the end of the 63rd day, the period between the date of application and the first day of coverage is a waiting period and no significant break in coverage occurred even though the actual period without coverage was 73 days.

Example 8. (i) *Facts.* Same facts as *Example 7*, except that *E*'s application for a policy in the individual market is denied.

(ii) *Conclusion.* In this *Example 8*, even though *E* did not obtain coverage following application, the period between the date of application and the date the coverage was denied is a waiting period. However, to avoid a significant break in coverage, no later than the day after the application for the policy is denied *E* would need to do one of the following: submit a substantially complete application for a different individual market policy; obtain coverage in the group market; or be in a waiting period for coverage in the group market.

(vi) *Other permissible counting methods*—(A) *Rule.* Notwithstanding any other provisions of this paragraph (b)(2), for purposes of reducing a preexisting condition exclusion period (but not for purposes of issuing a certificate under §146.115), a group health

plan, and a health insurance issuer offering group health insurance coverage, may determine the amount of creditable coverage in any other manner that is at least as favorable to the individual as the method set forth in this paragraph (b)(2), subject to the requirements of other applicable law.

(B) *Example.* The rule of this paragraph (b)(2)(vi) is illustrated by the following example:

Example. (i) *Facts.* Individual *F* has coverage under Group Health Plan *Y* from January 3, 1997 through March 25, 1997. *F* then becomes covered by Group Health Plan *Z*. *F*'s enrollment date in Plan *Z* is May 1, 1997. Plan *Z* has a 12-month preexisting condition exclusion.

(ii) *Conclusion.* In this *Example,* Plan *Z* may determine, in accordance with the rules prescribed in paragraphs (b)(2)(i), (ii), and (iii) of this section, that *F* has 82 days of creditable coverage (29 days in January, 28 days in February, and 25 days in March). Thus, the preexisting condition exclusion will no longer apply to *F* on February 8, 1998 (82 days before the 12-month anniversary of *F*'s enrollment (May 1)). For administrative convenience, however, Plan *Z* may consider that the preexisting condition exclusion will no longer apply to *F* on the first day of the month (February 1).

(c) *Alternative method*—(1) *Specific benefits considered.* Under the alternative method, a group health plan, or a health insurance issuer offering group health insurance coverage, determines the amount of creditable coverage based on coverage within any category of benefits described in paragraph (c)(3) of this section and not based on coverage for any other benefits. The plan or issuer may use the alternative method for any or all of the categories. The plan or issuer may apply a different preexisting condition exclusion period with respect to each category (and may apply a different preexisting condition exclusion period for benefits that are not within any category). The creditable coverage determined for a category of benefits applies only for purposes of reducing the preexisting condition exclusion period with respect to that category. An individual's creditable coverage for benefits that are not within any category for which the alternative method is being used is determined under the standard method of paragraph (b) of this section.

(2) *Uniform application.* A plan or issuer using the alternative method is required to apply it uniformly to all participants and beneficiaries under the plan or health insurance coverage. The use of the alternative method is required to be set forth in the plan.

(3) *Categories of benefits.* The alternative method for counting creditable coverage may be used for coverage for the following categories of benefits—

(i) Mental health;

(ii) Substance abuse treatment;

(iii) Prescription drugs;

(iv) Dental care; or

(v) Vision care.

(4) *Plan notice.* If the alternative method is used, the plan is required to—

(i) State prominently that the plan is using the alternative method of counting creditable coverage in disclosure statements concerning the plan, and state this to each enrollee at the time of enrollment under the plan; and

(ii) Include in these statements a description of the effect of using the alternative method, including an identification of the categories used.

(5) *Issuer notice.* With respect to health insurance coverage offered by an issuer in the small or large group market, if the insurance coverage uses the alternative method, the issuer states prominently in any disclosure statement concerning the coverage, that the issuer is using the alternative method, and includes in such statements a description of the effect of using the alternative method. This applies separately to each type of coverage offered by the health insurance issuer.

(6) *Disclosure of information on previous benefits.* See §146.115(b) for special rules concerning disclosure of coverage to a plan, or issuer, using the alternative method of counting creditable coverage under this paragraph (c).

(7) *Counting creditable coverage*—(i) *In general.* Under the alternative method, the group health plan or issuer counts creditable coverage within a category if any level of benefits is provided within the category. Coverage under a reimbursement account or arrangement, such as a flexible spending arrangement (as defined in section 106(c)(2) of the Internal Revenue Code),

does not constitute coverage within any category.

(ii) *Special rules.* In counting an individual's creditable coverage under the alternative method, the group health plan, or issuer, first determines the amount of the individual's creditable coverage that may be counted under paragraph (b) of this section, up to a total of 365 days of the most recent creditable coverage (546 days for a late enrollee). The period over which this creditable coverage is determined is referred to as the determination period. Then, for the category specified under the alternative method, the plan or issuer counts within the category all days of coverage that occurred during the determination period (whether or not a significant break in coverage for that category occurs), and reduces the individual's preexisting condition exclusion period for that category by that number of days. The plan or issuer may determine the amount of creditable coverage in any other reasonable manner, uniformly applied, that is at least as favorable to the individual.

(iii) *Example.* The rules of this paragraph (c)(7) are illustrated by the following example:

Example. (i) *Facts.* Individual *D* enrolls in Employer *V*'s plan on January 1, 2001. Coverage under the plan includes prescription drug benefits. On April 1, 2001, the plan ceases providing prescription drug benefits. *D*'s employment with Employer *V* ends on January 1, 2002, after *D* was covered under Employer *V*'s group health plan for 365 days. *D* enrolls in Employer *Y*'s plan on February 1, 2002 (*D*'s enrollment date). Employer *Y*'s plan uses the alternative method of counting creditable coverage and imposes a 12-month preexisting condition exclusion on prescription drug benefits.

(ii) *Conclusion.* In this *Example*, Employer *Y*'s plan may impose a 275-day preexisting condition exclusion with respect to *D* for prescription drug benefits because *D* had 90 days of creditable coverage relating to prescription drug benefits within *D*'s determination period.

[69 FR 78788, Dec. 30, 2004]

§ 146.115 Certification and disclosure of previous coverage.

(a) *Certificate of creditable coverage*—(1) *Entities required to provide certificate*—(i) *In General.* A group health plan, and each health insurance issuer offering group health insurance coverage under a group health plan, is required to furnish certificates of creditable coverage in accordance with this paragraph (a).

(ii) *Duplicate certificates not required.* An entity required to provide a certificate under this paragraph (a) with respect to an individual satisfies that requirement if another party provides the certificate, but only to the extent that the certificate contains the information required in paragraph (a)(3) of this section. For example, in the case of a group health plan funded through an insurance policy, the issuer satisfies the certification requirement with respect to an individual if the plan actually provides a certificate that includes all the information required under paragraph (a)(3) of this section with respect to the individual.

(iii) *Special rule for group health plans.* To the extent coverage under a plan consists of group health insurance coverage, the plan satisfies the certification requirements under this paragraph (a) if any issuer offering the coverage is required to provide the certificates pursuant to an agreement between the plan and the issuer. For example, if there is an agreement between an issuer and a plan sponsor under which the issuer agrees to provide certificates for individuals covered under the plan, and the issuer fails to provide a certificate to an individual when the plan would have been required to provide one under this paragraph (a), then the issuer, but not the plan, violates the certification requirements of this paragraph (a).

(iv) *Special rules for issuers*—(A)(*1*) *Responsibility of issuer for coverage period.* An issuer is not required to provide information regarding coverage provided to an individual by another party.

(*2*) *Example.* The rule of this paragraph (a)(1)(iv)(A) is illustrated by the following example:

Example. (i) *Facts.* A plan offers coverage with an HMO option from one issuer and an indemnity option from a different issuer. The HMO has not entered into an agreement with the plan to provide certificates as permitted under paragraph (a)(1)(iii) of this section.

(ii) *Conclusion.* In this *Example,* if an employee switches from the indemnity option to the HMO option and later ceases to be